

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003
(No. City Hospital)

File No. 13364
Registered No. 3685
St. Ward

2. FULL NAME

(a) Residence. No. 2701 Broadway Quincy Ills 23 Ward. Quincy Ills
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male White Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 5th 1903

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

24

2

12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Iowa

10. NAME OF FATHER

Charles F. Jarvis

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

12. MAIDEN NAME OF MOTHER

Effie P. Westfall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Iowa

14.

INFORMANT
(Address)

Charles F. Jarvis
Quincy Ills

15.

FILED

APR 18 1927

Mar C. Starkeoff

REGISTRAR

✓

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 17th 1927

17.

I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 11 30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
(Internal)

crushed between two freight cars
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Accident

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

Did AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Drown M.D.
4/18/27 (Address) Dr. P. Corcoran

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Quincy Ills

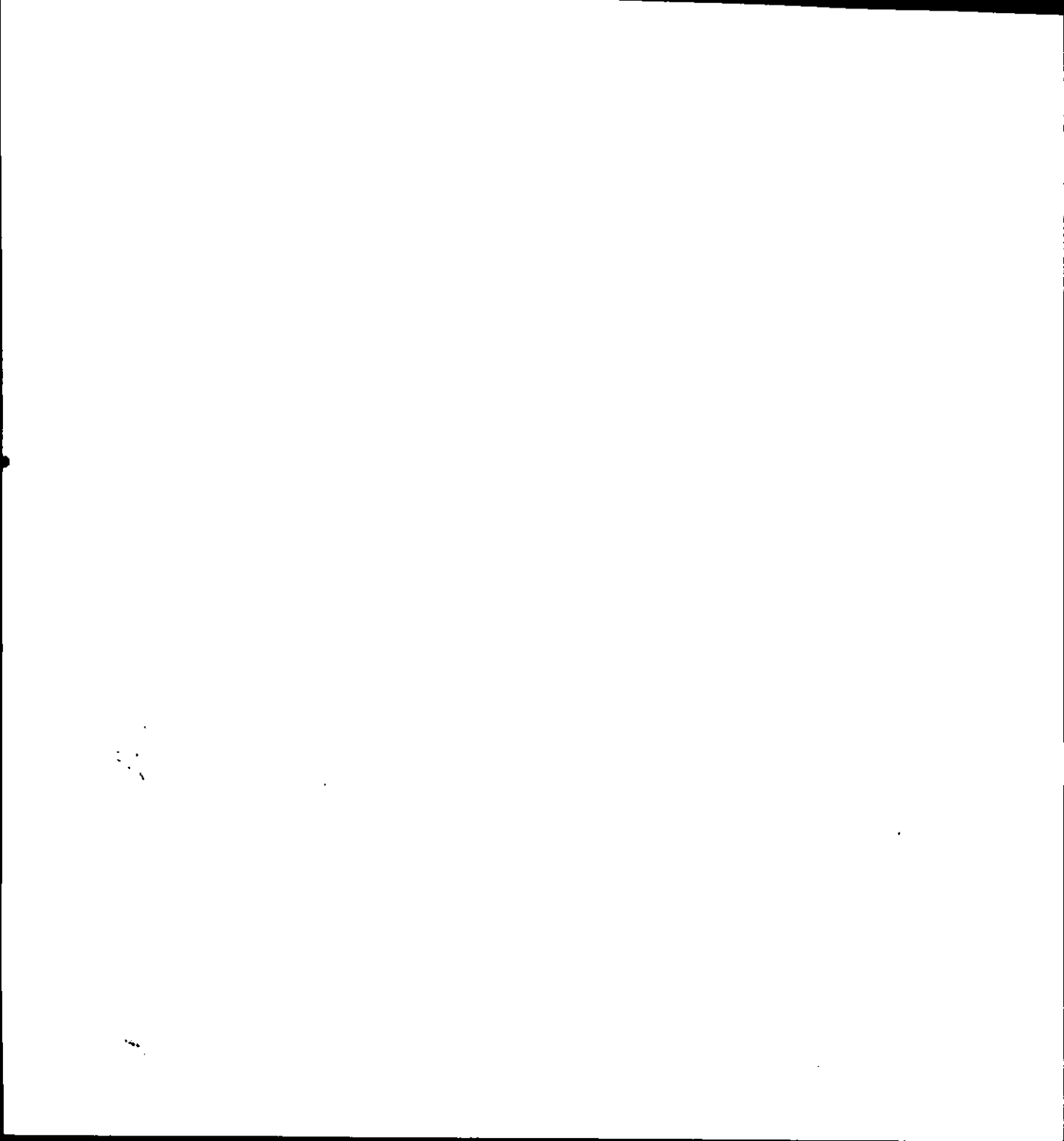
April 18 1927

20. UNDERTAKER

ADDRESS

Math. Hermann & Son 4103rd Flourissant Ave

Exact statement of OCCUPATION is very important. Do not leave blank terms, so that it may be properly classified.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City St. Louis (No.)

Registration District No. 791
Primary Registration District No. 7003

File No.
Registered No. 2685
St. Ward)

2. FULL NAME

Victor L. James

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

m

4. COLOR OR RACE

w

**5. SINGLE, MARRIED, WIDOWED OR
DIVORCED (write the word)**

m

**5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF**

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

**9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)**

10. NAME OF FATHER

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)**

12. MAIDEN NAME OF MOTHER

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)**

**14. INFORMANT
(Address)**

15. FILED - 9 27 1910
max b Starks
REGISTERED

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Apr 17 1927

17.

I HEREBY CERTIFY That I attended deceased from

19..... to 19.....
that I last saw him alive on, 19....., and that
death occurred on the date stated above at

THE CAUSE OF DEATH WAS AS FOLLOWS:

thick inspirations
terminal crushed the
two two freight
cars
Accident
(No Auto)
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) H. D. Smith

, 19 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-13364